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Effect of Ambulatory Case Mix on Hospitalization Rates

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Total national expenditures for the Medicaid program increased 237 percent between 1973 and 1979--an average annual compound rate of growth of 14.4 percent (Muse and Sawyer 1982, p. 25). Even after allowance is made for the growth in the number of Medicaid recipients (10 percent between 1973 and 1979) and inflation in medical care prices (74 percent between 1973 and 1979),[1] program costs still grew at an average annual compound rate of growth of 7.3 percent. Increases of this magnitude generated considerable policy interest and helped instigate the rather dramatic changes in the Medicaid program after President Reagan took office in 1980.

The growth in Medicaid expenditures for the 1973-79 period varied by type of service, with hospital outpatient services growing at the largest rate (19 percent per year, doubling in less than 4 years, Muse and Sawyer 1982, p. 34).[2] However, hospital outpatient services were only 4 percent of the total program costs in 1979, and just under 16 percent of all ambulatory costs. Short-term hospital expenditures, by contrast, accounted for 28 percent of total Medicaid expenditures in 1979. Not only are short-term hospital expenditures the largest single category of costs, but their increases (13 percent per year compounded) have also been dramatically rapid.

THE POLICY PROBLEM

Hospital use is of fundamental policy interest, not only because of the hospital expenditures' share of the budget, but also because many have argued

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[1] Economic Report of the President 1982, U.S. Government Printing Office, Washington, D.C., 1982, Table B-53.

[2] For Medicare expenditures, the rate of inflation for uninsured in-hospital outpatient services was even higher, at 27 percent a year, compounded.

that hospital use is one of the sectors of the health care industry most amenable to change. Of particular interest is the relationship between the different settings for ambulatory care and rates of admission to the short-term hospital. Our study focuses on this relationship by examining the expenditures and health care use patterns for two groups of Medicaid eligibles in California between 1976 and 1978.[3]

When we examine hospitalization rates across the different ambulatory care settings, we find that an AFDC female whose predominant source of ambulatory care is an outpatient department of a hospital is nearly twice as likely to be hospitalized as her counterpart whose PSC is a private physician's office. This finding leads to an obvious question:

> Are certain ambulatory care settings simply more willing to hospitalize patients, or can at least some of these differences be accounted for by differences in the health status of patients who use these different settings?

Lion and Altman (1981), for example, argue that there are no substantial case mix differences between patients seen in private practice and patients seen in outpatient departments. If this is in fact the case, then what explains the different hospitalization rates? Our paper addresses this issue on the basis of data on AFDC female and disabled Medicaid eligibles in California. Our results should be interpreted in light of the fact that California is one of a minority of states that uses a charge-based system of payment, not only for private physician visits but also for visits to an OPD. Since charge-based (rather than cost-based) payment systems are being introduced into more and more facets of health care and in more and more areas of the country, however, the generalizability of results for such a system is increasing.

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[3] Disabled and AFDC (Aid to Families with Dependent Children) are two of the categories under which persons become eligible for the Medicaid program.

The plan of the paper is first to describe the data used for this study and the distribution of PSC for the two study samples. Next, expenditures and hospitalization rates are compared according to PSC. Then hospital discharge diagnoses are investigated to help clarify why the hospitalization rates are so different by PSC. Finally, the importance of these descriptive findings, particularly in terms of how they relate to reimbursement policy, are discussed.

DATA AND DISTRIBUTIONS OF PREDOMINANT SOURCE OF AMBULATORY CARE

The data on which the study is based were computed from eligibility and medical claims records for two groups of the California Medicaid (Medi-Cal) population. The first group consisted of nonaged (under 65 years of age), female AFDC recipients of cash assistance, excluding the 7-14 year old cohort and those who lived in Los Angeles county.[4] The sample for this group was drawn from Medi-Cal eligibility records in a manner which oversampled two age cohorts (less than 1 year, and 50-64 year olds) and rural counties. The data presented have been corrected, however, for age and geographic stratification.[5] The second group consisted of the disabled, again excluding those who lived in Los Angeles county. The sample for this group was a systematic random sample of the Medi-Cal eligibles. The data presented in this paper are based on 8,622 female AFDC and 8,151 disabled eligibles evenly distributed over the three years 1976-1978.

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[4] Los Angeles county was excluded from the study because of a unique reimbursement policy for outpatient facilities which did not permit identification of individual services provided to patients seen in hospital outpatient departments. Also, for efficiency in data processing, drug claims were not included and males were excluded from the AFDC sample.

[5] The total sample drawn was approximately 50,000 per year for the AFDC sample and 10,000 per year for the disabled; the results presented here are based on smaller subsamples.

The predominant source of care concept (PSC) is intended to reflect the type of setting in which an individual typically receives ambulatory medical care (physician visits). Our presumption is that the PSC reflects a beneficiary's usual point of entry into the health care system.

A PSC was assigned to each Medicaid eligible who had an ambulatory physician visit over a given 6-month period on the basis of the frequency of visits that the person had to each of the various settings. The setting with the highest number of visits by the individual during the period was selected as the PSC for that person. Two levels of aggregation of the PSC were used. The first used four setting alternatives: private physician's office; an outpatient department (OPD) in a hospital; an emergency room (ER) in a hospital; and a clinic.[6] The second level of aggregation divided the private physician's office into general practice and specialist, and the hospitals into public and private hospital OPDs and ERs. Each level of aggregation also accounted for the nonusers, i.e., persons who received no ambulatory physician visits during the six months. Including nonusers as a separate category ensures that all eligibles are included in one of a set of mutually exclusive categories. The nonuser category includes those who used medical care without being a user of ambulatory physician visits; such occurrences are rare. This paper focuses on the first level of aggregation (four settings of care), since the level of precision achievable with the eight settings of care is frequently inadequate for our purposes. (Estimates for all settings are provided in Appendix A.)

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[6] Generally, clinics are free-standing (i.e., not attached to a hospital) medical centers that span a wide range, including primary care clinics, free clinics, neighborhood health centers, and community clinics. They provide general medical care, family planning services, and mental health care to varying degrees.

Tables 1 and 2 show the overall distributions of PSC as well as the distributions of PSC by age, sex, and rural residence in 1976 and 1978, for the female AFDC eligibles and the disabled eligibles, respectively. For both groups, more than half received ambulatory care primarily in private physicians' offices.[7]

Perhaps the most striking difference between these two groups of eligibles appears in the age distributions; the age differences are not surprising, of course, given the different eligibility requirements for the two groups. Almost 50 percent of the disabled are between 50 and 64 years of age, whereas only 3 percent of the AFDC females are in this age cohort. Similarly, only slightly more than 1 percent of the disabled are less than 6 years old, compared with just over 25 percent of the AFDC females. Another substantial difference between the two groups is the proportion who are nonusers of ambulatory physician visits: 23 percent of the AFDC females compared with 33 percent of the disabled (1976 data).

Between 1976 and 1978 there were slight changes in the distribution of PSCs for each group, changes that differed by group. The AFDC females increased their relative use of the OPD and clinic somewhat, whereas the disabled used the private physician's office slightly more frequently.[8] In addition, it appears that there was some decrease in the proportion of nonusers among the disabled, with essentially no change among the AFDC females.

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[7] This is roughly comparable to what has been found for the population as a whole from the Health Interview Surveys' published data. Note that the HIS omits nonusers, but 68 percent of the users said their place of care was a doctor's office. See Health, United States, 1978, Public Health Service, DHEW Publication No. (HRA) 78-1272, p. 268. Our estimates of the incidence of ambulatory care visits to OPDs and ERs seem lower than those reported in Dobson et al. (1981), although their numbers were visits, not predominant source of care, and their time period was different.

[8] This was especially true for specialists, see Table A2.

Table 1

Distribution of Predominant Source of Care by Age, Year and Geographic Location for Female AFDC Medicaid Eligibles California, 1976-1978

(Percent)

Location and Age	Year	Weight[b]	Predominant Source of Care[a]					Total
			Private Office	ER	OPD	Clinic	Nonuser of Ambulatory Care	
All	1976	100.0	58.0	9.4	6.9	2.5	23.5	100.0
	1978	100.0	57.4	8.2	8.3	3.6	22.5	100.0
Rural Counties[c]	1976	11.9	55.4	8.3	6.2	4.0	26.1	100.0
	1978	12.3	50.2	7.3	7.6	9.1	25.8	100.0
Age								
Less than 1	1976	3.7	71.5	8.4	9.8	2.1	8.2	100.0
	1978	2.4	72.0	6.3	10.8	3.1	7.8	100.0
1-6	1976	24.9	48.4	11.7	6.1	2.8	31.1	100.0
	1978	24.5	58.6	10.7	4.7	1.2	24.8	100.0
15-24	1976	30.7	58.7	10.4	6.3	2.6	22.1	100.0
	1978	30.0	53.4	7.8	10.1	3.9	24.8	100.0
25-34	1976	24.2	60.3	7.7	8.2	2.2	21.5	100.0
	1978	25.6	58.3	8.1	9.7	5.5	18.5	100.0
35-49	1976	13.8	66.0	5.8	6.4	2.0	19.8	100.0
	1978	14.4	59.4	6.3	7.9	3.4	23.1	100.0
50-64	1976	2.8	61.9	3.1	8.7	3.4	22.9	100.0
	1978	3.1	66.0	2.1	10.5	2.6	18.8	100.0
(Sample Size)			(5171)	(593)	(701)	(253)	(1904)	(8622)

NOTE: Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Six age cohorts are included. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles county and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred. ER is emergency room. OPD is outpatient department.

b. Weight is the percent of the total sample, by year, in that row.

c. "Rural" includes 33 counties with low population densities and few population centers.

Table 2

Distribution of Predominant Source of Care by Age, Year and Geographic Location for Disabled Medicaid Eligibles California, 1976-1978

(Percent)

Location and Age	Year	Weight[b]	Predominant Source of Care[a]					Total[c]
			Private Office	ER	OPD	Clinic	Nonuser of Ambulatory Care	
All	1976	100.0	50.2	5.3	9.8	1.8	32.9	100.0
	1978	100.0	54.5	4.4	8.6	1.9	30.8	100.0
Rural Counties[d]	1976	13.8	54.9	4.2	7.1	3.7	30.0	100.0
	1978	13.3	58.5	5.3	6.9	2.0	27.3	100.0
Female Distribution	1976	53.2	57.1	4.3	10.5	2.0	26.2	100.0
Male Distribution	1978	46.0	43.1	6.6	9.3	1.7	39.4	100.0
Age								
Less than 1	1976	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	1978	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1-6	1976	1.0	38.7	12.9	3.2	0.0	45.2	100.0
	1978	1.3	57.2	5.7	5.8	0.0	31.4	100.0
7-14	1976	2.9	41.4	4.6	8.1	1.2	44.8	100.0
	1978	2.7	57.5	2.7	2.7	2.7	34.3	100.0
15-24	1976	11.7	36.6	6.6	6.1	1.4	49.3	100.0
	1978	10.4	40.5	6.9	9.3	1.4	42.9	100.0
25-34	1976	15.5	40.6	7.2	9.3	2.0	40.9	100.0
	1978	16.4	43.0	6.2	3.5	2.9	41.2	100.0
35-49	1976	19.7	50.2	6.3	10.3	1.9	31.4	100.0
	1978	19.7	49.7	4.6	10.6	2.1	31.8	100.0
50-64	1976	49.1	57.2	3.9	11.0	1.9	26.2	100.0
	1978	49.5	62.8	2.1	8.7	1.5	24.1	100.0
(Sample Size)			(4290)	(396)	(739)	(144)	(2579)	(8151)

NOTE: Based on a sample of 8,151 disabled eligibles. Those aged 65 years or older are excluded. Los Angeles county and drug claims are excluded. Eligibles who received care in a long-term setting are included in these data; 0.8 percent were missing data on their sex.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred. ER is emergency room. OPD is outpatient department.

b. The percent of the total sample, by year, in that row.

c. Detail may not add to 100.00 due to rounding.

d. "Rural" includes 33 counties with low population densities and few population centers.

MEDICAID COSTS AND THE DIFFERENT SETTINGS OF CARE

The overall pattern of expenditures (cost) per eligible per six-month period for medical care and hospitalization by the two most frequently used types of PSC (private physician's office and OPD) is shown in Table 3.[9] For both the disabled and the AFDC females, inpatient costs accounted for nearly half the total cost--$251 and $521 for private office and OPD, respectively. (This total includes all care except drugs. See Appendix Tables A-3 and A-4.) For both groups, the hospitalization rate for patients whose PSC was an OPD was higher than the rate for patients whose PSC was a private physician's office, although the magnitude of the difference was much greater for the AFDC group than for the disabled group. For the AFDC sample, beneficiaries whose PSC was an OPD had a hospitalization rate that was almost twice that of beneficiaries whose PSC was a private physician's office (20 versus 11 percent). For the disabled the difference was 16 versus 20 percent, respectively. The increased hospitalization naturally causes greater costs per beneficiary. In fact, for the AFDC sample, 92 percent of the difference of $181 in mean total cost between a private physician's office and an OPD is accounted for by the difference in the hospitalization rate. (As the Appendix tables indicate, the average lengths of stay and cost per hospital day are quite similar for patients from these two ambulatory settings.) For the disabled, differences in hospitalization costs account for 86 percent of the difference in mean total costs.

These results are striking. In particular, they contradict the view that OPDs are more costly to Medicaid than other settings because of costs specific

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[9] Although we use cost and expenditures interchangeably, these statistics do not necessarily represent true economic (or resource) costs.

Table 3

Mean Medicaid Cost Per Eligible and Percent Hospitalized, Eligibility and Source of Care, California, January-June 1976-1978

Eligibility Status	Cost Parameter	Predominant Source of Care[a]		
		Private Physician's Office	Hospital OPD	Total[b]
Female AFDC	Percent Hospitalized[c]	11	20	9
	Inpatient Costs[d]	$130	$297	$121
	Percent of Total	(44)	(62)	(48)
	Total Costs	$296	$477	$251
Disabled	Percent Hospitalized[c]	16	20	13
	Total Inpatient Costs	$296	$678	$318
	Percent of Total	(53)	(68)	(61)
	Short Term	$274	$501	$246
	Long Term	$ 22	$177	$ 72
	Total Costs	$555	$1,000	$521

NOTE: Data include deliveries. See Appendix tables for details and qualifications.

[a] Defined to be the mode (most frequent) of the setting where patients received their ambulatory physician visits.

[b] Includes all eligibles, not just the two sources of care shown here. See Appendix tables for details.

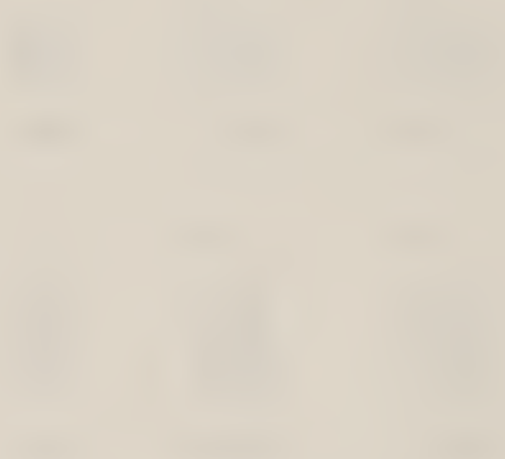
[c] Includes short and long term care facilities, but the latter are seldom used by AFDC females.

[d] Short term facilities only.

[illegible]

[illegible]

[illegible]



[illegible]

to the OPD (for example, social workers, hospital overhead).[10] The policy issue is clearly differences in hospitalization rates across different settings.

Four potential explanations for differences in hospitalization rates are shown in Table 4. The first two focus on potential differences among patients and physicians. The third has to do with the general perception of OPDs as an institution for episodic care lacking in what might be called continuity of knowledge between physician and patient. The fourth ascribes more venal motives than do the others. It postulates that hospitals, for economic reasons, use the OPD as a source of inpatients to fill hospital beds beyond what proper medical judgment would prescribe.

With respect to the first explanation, that OPDs and other hospital settings such as the emergency room frequently are staffed by medical residents, would provide some support to the first explanation if residents are more likely to hospitalize patients than are other physicians. We could not test this hypothesis because the medical-claims data used in this project identified a physician's specialty but did not identify whether or not the physician was a medical resident in training. Anecdotal evidence suggests that it may have some validity. Nor can we say anything about the third potential explanation (lack of continuity of care in the OPD).

With respect to the second explanation, whether or not OPDs have a different case mix of patients compared to private practices is a major issue, which has been addressed by Lion and Altman (1981) among others. Our results are able to shed new light on this issue, as discussed in the next section.

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[10] The detailed data in Appendix A do indicate that certain services (such as pathology) cost more per beneficiary in some settings than others, but the differences do not add up to much.

Table 4

Potential Explanations for Higher Hospitalization Rates For OPDs

Potential Explanation	Remarks
1. Physicians practicing in the OPDs are different from their counterparts in private offices in ways that lead to more conservative treatment.	1. E.g., younger or less experienced physicians in OPDs.
2. Patients seen in hospital OPDs have a different health status than patients seen in private offices.	2. E.g., more serious or different presenting symptoms for OPD patients. Perhaps the OPD is a referral center.
3. Patients and physicians in the two settings may not be different, but the interaction in an OPD, with its episodic care lacking continuity of patient-physician contact, may lead to more conservative treatment.	3. E.g., a physician does not know the parent of a sick child well enough to trust that the parent would contact the physician if conditions worsen. Consequently, the physician takes a more conservative approach and hospitalizes the child.
4. The OPD may be a "side door" to the hospital, a source of inpatients, used to admit patients at a rate greater than indicated by proper medical practice.	

With respect to the fourth explanation, although we cannot provide strong evidence, our results on case mix allow us to draw at least tentative conclusions.

Our methodological approach is to examine the issue of hospitalization by using the Medicaid claims data to categorize the diagnoses on the hospital discharge records for all the Medicaid beneficiaries in our two eligible groups according to degree of physician discretion involved. This, then, allows us to compare hospitalization rates across the two major PSC alternatives, with the objective of identifying the role played by physician discretion.

DISCRETION IN THE CHOICE OF WHETHER OR NOT TO HOSPITALIZE

The range of conditions for which patients are hospitalized is substantial, as is the range of discretion and judgment required by and conferred on the physician. On the one hand, conditions such as acute appendicitis or the delivery of a baby do not permit much latitude for physician discretion about whether or not to hospitalize the patient. On the other hand, a hernia is normally subject to considerable discretion about whether to hospitalize and when. In order to analyze the effects of such differences, we divided the discretion continuum into six categories on the basis of the degree of discretion involved, and used expert medical judgment to allocate each diagnosis on the hospital discharge records of our sample of Medicaid eligibles to one of the six categories:[11]

A. No discretion according to generally prevailing medical practice, as to the need or time to hospitalize; condition generally not correlated with overall health status. (E.g., acute appendicitis, normal delivery.)

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[11] We wish to thank Robert Berenson, M.D., for reviewing the categorization scheme and assigning the diagnoses to particular categories.

B. No discretion as to the need or timing of hospitalization; condition generally correlated with overall health status. (E.g., acute myocardial infarction, cerebral hemorrhage.)

C. Discretion in decision to treat a condition which would typically require hospitalization but is basically a quality of life choice; timing not urgent. For example, surgery that is discretionary to the extent that the condition is not life threatening but life would be more "comfortable" with the condition corrected (e.g., hernia, cataract, uterovaginal prolapse). Normally, physicians would advise surgery for these conditions provided a patient had medical insurance or the economic resources to pay for the medical care.

D. Not enough information on the medical claim to classify the diagnosis; retrospective classification of diagnosis not possible. (E.g., "other" bacterial diseases, "other" diseases of thyroid gland.)

E. Treatment modality and hospitalization both open to choice and judgment depending on the diagnosis and individual patient severity, but not merely on information about the patient. These diagnoses represent medical conditions about which accepted medical opinion would permit choice of treatment modality or choice of treatment and would depend on patient severity even within given diagnoses. (E.g., diabetes mellitus, drug dependence, acute bronchitis.)

F. Discretion of the physician required, but hospitalization not typical for this condition. (E.g., mumps, chickenpox, acute tonsillitis.)

Categories A and B are similar in that the hospitalization decision involves no discretion. The difference, conceptually speaking, is that B may provide some measure of general health status. While conceptually appealing, however, the frequencies of B diagnoses were too small to guarantee its empirical reliability as an indicator. Consequently, in our text discussion we treat A and B as one category. (In Appendix A they are shown separately.) Categories C and E also are similar in that both involve discretion and choice. The difference between them is that category C diagnoses generally do not

permit choice about how to treat a given condition,[12] only whether to treat. Category E diagnoses, by contrast, permit a choice about both whether and how to treat. Categories D and E are similar in that in both cases the diagnosis provides no information about severity, and if more complete information on the patient were available they might receive designations other than D or E. They differ in that category E diagnoses will usually permit discretion on whether and how to treat the patient. For category D there is no such presumption.

The distribution by physician discretion of the 1907 hospitalizations for our sample of 16,000 Medicaid eligibles is shown in Table 5. On the basis of hospital discharge diagnoses, the OPDs and private physicians' offices had a clearly different patient mix of Medicaid eligibles.[13] For example, urgent cases with no discretion (categories A and B) accounted for more than half the hospitalized AFDC females whose PSC was an OPD, versus about a third (34.4 percent) for those whose PSC was a physician's office. For the disabled the difference in percentage by PSC in categories A and B was similar although not as dramatic, with 24 percent for OPD and 19 percent for physician's private office. The pattern is reversed for discretionary "quality-of-life" hospitalization (category C) and discretionary and choice of treatment modality hospitalizations (category E). The unknown category (D) was also more weighted towards the private office.

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[12] There were a few cases that would permit choice about whether to treat as an in- or outpatient, but they constituted a very small fraction of the case total.

[13] The chi-square statistic for test of the null hypothesis of similar populations in both settings, as measured by their distributions across categories, indicates rejection of the null hypothesis at an alpha level of less than 0.001.

Table 5

Distribution of Hospital Diagnoses By Degree of Discretion Source of Care, and Eligibility Status, California, 1976-1978

Diagnosis Group	Eligibility Status	Predominant Source of Care[c]		(Private Office less OPD)
		Private Office	OPD	
A, B. Definite Hospitalization; No Choice of Timing	AFDC Female[a]	34.4%	56.4%	-22.0%
	Disabled[b]	19.0	23.7	-4.7
C. Definite Hospitalization; Quality of Life Choice; Generally Non-Urgent	AFDC Female	11.5	3.8	7.7
	Disabled	8.0	4.3	3.7
D. Don't Know; Not Enough Information	AFDC Female	19.9	12.7	7.2
	Disabled	28.5	26.8	1.7
E. Treatment Modality and Hospitalization Open to Choice and Judgment	AFDC Female	25.8	23.8	2.0
	Disabled	34.2	29.5	4.7
F. Usually Not Hospitalized	AFDC Female	8.1	3.3	4.8
	Disabled	10.3	15.8	-5.5
Total	AFDC Female	100.0	100.0	0
	Disabled	100.0	100.0	0

a. Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for six continuous months. Los Angeles county and drug claims are excluded. Those aged 7-14 and 65 or older are excluded. Data are weighted to reflect age cohort and geographic stratification. Eligibles who received care in a long-term care setting are excluded from these data.

b. Based on a sample of 8,151 disabled eligibles. Los Angeles county and drug claims are excluded. Those aged 65 or older are excluded. Eligibles who received care in a long-term care setting are not included in these data.

c. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. OPD is outpatient department.

These frequencies suggest the following:

> In terms of physician discretion regarding hospitalization, it appears that the patients from OPDs are more likely to have diagnoses in the less discretionary categories (A and B). In other words, a greater proportion of the hospitalized patients from OPDs are hospitalized for conditions which have little or no physician discretion, and a greater proportion of patients from private offices are hospitalized for conditions which involve physician discretion or choice (C).

The preceding discussion has focused on hospital discharge diagnoses. These may not give the complete story, however, because some care settings may treat discretionary cases on an outpatient basis--which would not then appear as inpatient records. To deal with this potential gap in our data, we also constructed an index of 11 selected surgical procedures generally requiring physician discretion.[14] Table 6 shows the distributions of these categories of surgical procedures by PSC for our two Medicaid subsamples. These data confirm the hypothesis that, compared to private practice patients, patients whose predominant source of care was an OPD received dramatically less discretionary surgery. Both the AFDC females and the disabled patients whose PSC is a private physician's office received three and a half to four and a half times as much discretionary surgery as did the patients with the OPD as their PSC. Patients from OPDs did tend to receive a smaller proportion of their discretionary surgery on an inpatient basis compared to the patients from private offices; however, the differences were not enough to change the basic conclusion arrived at from the inpatient data that patients whose PSC was an OPD received less discretionary surgical care than did the patients from private offices.

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[14] We are indebted to Helen Smits M.D., who selected the discretionary surgery procedures.

Table 6

Mean Costs and Frequency per Eligible of Selected "Discretionary" Surgical Procedures for Medicaid Eligibles by Predominant Source of Care and Eligibility Status, California, 1976-78

Measure	Eligibility Status[b]	Predominant Source of Care[a]		
		Private Office	OPD	Total[c]
Total Dollars Paid	Female AFDC	1.48	0.35	0.97
	Disabled	2.94	0.65	1.69
Inpatient Dollars (% of Total)	Female AFDC	44.15	38.58	43.98
	Disabled	53.04	3.68	50.30
Total RVUs	Female AFDC	3.00	0.86	1.96
	Disabled	7.14	0.04	4.02
Inpatient RVUs (% of Total)	Female AFDC	51.84	50.72	51.90
	Disabled	57.91	3.57	55.92
Total Visits	Female AFDC	0.04	0.02	0.03
	Disabled	0.12	0.03	0.07
Inpatient Visits (% of Total)	Female AFDC	21.63	12.31	19.85
	Disabled	7.99	5.26	8.14

NOTE: Discretionary surgical procedures comprises 11 procedures that generally require the discretion of the physician. Examples include arthrocentesis and cataract extraction. See Appendix tables for details.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory visits occurred for a given patient. OPD is outpatient department.

b. Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Those aged 7-14 years old and 65 or older are excluded. Data are weighted to correct for age cohort and geographic stratification. The statistics for the disabled are based on a sample of 8,151 disabled eligibles. Those aged 65 years or older are excluded. Los Angeles county and drug claims are excluded.

c. Includes all sources of care, not just the two categories shown here.

Let us now return to categories A and B (no discretion), and ask: What were the major diagnoses that differentiated the patients whose PSC was the OPD from those whose PSC was a private physician's office, and how does the answer to this question affect our basic focus on the cost of medical care across different settings? Nor surprisingly, delivery is the most frequent diagnosis in these categories for AFDC females. For some reason, OPDs have a substantially larger proportion of the total deliveries.[15] In fact, the hospitalization rate for females whose PSC is an OPD drops from 20 percent to 10 percent when deliveries are excluded, which is only slightly higher than the analogous proportion of those whose PSC is a private physician's office. No obvious diagnoses account for the greater proportion of the disabled hospitalizations in categories A and B for OPD than for private office patients. But it should be recalled in this connection that the difference in categories A and B for the disabled between OPDs and private offices, while substantial, was small compared to the difference observed for AFDC women.

The effect of excluding pregnancies for the AFDC population is shown in Table 7. With pregnancies excluded, we observe that average total cost per beneficiary for six months for patients whose PSC was an OPD was lower ($264) than the cost for patients whose PSC was a private office ($307). The exclusion of pregnancies, thus, actually increased the average inpatient costs for the private practice patients slightly, while lowering them substantially (60 percent) for OPD patients.

The data in Table 7, thus, tell a much less dramatic story about differences in hospitalization rates and total costs across these settings of

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[15] It is a separate issue as to why OPDs have a greater proportion of pregnancies than do private offices. Anecdotal accounts indicate that the fee schedule is such that it acts as a disincentive for private obstetricians in California to treat pregnant Medicaid women.

Table 7

Mean Medicaid Cost Per Eligible and The Percent Hospitalized, Excluding Deliveries, By Eligibility and Source of Care, California, January-June 1976-1978

Eligiblity Status	Cost Parameter	Predominant Source of Care[a]		
		Private Physician's Office	Hospital OPD	Total Sample[b]
Female AFDC	Percent Hospitalized	9 (11)	10 (20)	8 (9)
	Inpatient Costs	$110 ($130)	$120 ($297)	$111 ($121)
	Percent of Total	46 (44)	45 (62)	47 (48)
	Total Costs	$307 ($296)	$264) ($477)	$234 ($251)
Disabled	Percent Hospitalized	16	20	13
	Inpatient Costs	$296	$678	$318
	Percent of Total	53	68	61
	Short Term	$274	$501	$246
	Long Term	$ 22	$177	$ 72
	Total Costs	$555	$1,000	$521

NOTE: For easy reference, the data from Table 3 on female AFDC recipients including those with deliveries are shown in parentheses. See Appendix tables for details and qualifications.

[a] Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient.

[b] Includes all eligibles across all the sources of care and not just the two shown here. See Appendix tables for details.

ambulatory care for the AFDC population once pregnancies are excluded. The clearly observed nonrandom pattern for pregnancies is an indication of "self-selection" by AFDC patients, but whether this extends to other conditions or along severity lines within given conditions is not clear from our data. For the disabled population pregnancy is not relevant, and the original OPD-private office differences remain.

Let us now return to the potential explanations (Table 4) for the higher hospitalization rates for patients whose PSC is the OPD. What have these data and analyses shown? First, it would appear that there is truth to the second potential hypothesis, that is, that the mix of patients in the two settings is different. Specifically, the frequency of Type A and B hospitalization diagnoses (no discretion) are such that much of the difference in hospitalization rates can be explained by case-mix differences. This is true for both the disabled and the AFDC female eligibles, with pregnancies being of particular importance for the latter. We do not think these results are conclusive, but clearly there are differences between private practice and OPD patients that support this basic hypothesis.

Our analysis has not shed much light on the potential differences in physicians practicing in OPDs or in the interaction of patients and physicians in the OPD (the first and third explanations). As for the fourth explanation regarding possible venal behavior or the part of hospital physicians practicing in OPDs, although these results again do not provide conclusive evidence, the data on discretionary hospital diagnoses (category C in Table 4) and on selected discretionary surgical procedures (Table 6) do not support the fill-the-bed hypothesis. If physicians were going to help keep the hospital full for nonmedical reasons, it would seem that a likely starting point would be

discretionary surgery, and one would expect, in consequence, to see higher proportions of discretionary surgery cases.[16]

Before we proceed to discuss the implications of our results, we should note that our results appear to be inconsistent with research by Lion and Altman (1981) who found that the case mixes of patients seen in OPDs and patients seen in private practices were substantially similar in terms of case complexity; according to their work, if there are differences they are small, with OPD patients being perhaps "15 percent more complex." Do the Lion and Altman results in fact conflict with those presented here, or are the methodologies and populations studied sufficiently different to account for the different results?

It is immediately clear that there are, in fact, differences between the methodologies and populations of the two studies. Lion and Altman analyzed patient-physician contacts from a national sample of primary care physicians. They specifically excluded all visits to an emergency room and all visits to obstetricians and gynecologists. Our sample, by contrast, was restricted to two subsets of the California Medicaid population. In addition, our study sample considered all sources of care, including emergency room visits and visits to obstetricians and gynecologists, and focused on a six-month patient history. In spite of these differences, however, we believe the studies are comparable enough for it to be useful to list some areas of agreement and disagreement between the two studies. First, the areas of agreement:

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[16] It should be recalled that "discretionary" does not suggest unnecessary. In fact, our definition of discretionary includes the notion that patients benefited from the corrective procedures.

Another item which tends to mitigate against hypothesis (4) is the absence of a dramatically higher hospitalization rate for patients with a PSC of the emergency room compared to patients from private practice sources of care.

Excluding pregnant women and their greater proclivity to use an OPD rather than a private physician's office, it would appear that the magnitude of the likely differences in "patient complexity" between the two settings is not extraordinary. Our conclusions are based generally on the intensity of physician visits in the two settings and on the likelihood of hospitalization. We are not as confident of the precise magnitude of the differences as are Lion and Altman, but the data of this project would not be consistent with reimbursements for OPDs two or three times as great as private physicians receive based on case complexity. Differences of this magnitude may seem absurd to some, but they do occur in some Medicaid programs.

Second, the areas of disagreement:

The substantial use of the OPD for obstetrical and gynecological care suggests that there are case mix differences between OPD caseloads and private practices. Lion and Altman, of course, have excluded such visits from their analysis, but it would seem that this is a critical exclusion with significant implications for the generalizability of their results. The differences in the incidence of hospitalizations for diagnoses with no physician discretion about admission (categories A and B), which include not only deliveries but other conditions as well, suggest that the case mix differences extend beyond Ob/Gyn, especially when one considers the

disabled, who are not likely users of Ob/Gyn services. These differences in case mix may or may not contradict Lion and Altman's results about case complexity per se, but they certainly are not consistent with the notion that OPDs and private practices treat the same mix of patients. We know these differences in case mix lead to dramatic differences in the use of inpatient care; they may well have an impact on the cost of ambulatory care as well.

CONCLUSIONS AND IMPLICATIONS

The conclusions and implications of our analysis address two major issues: program costs and patterns of care, and basic reimbursement methods. Each is discussed in turn.

Program Costs and Patterns of Care

The following appear to be the major conclusions of this analysis with respect to California Medicaid between 1976 and 1978:

- Private physicians' offices were the predominant source of care for the majority of both the disabled and AFDC females.
- Hospital OPDs were the predominant source of care for approximately 10 percent of the eligibles. Although this study was restricted to California Medicaid, the aggregate national data suggest that California may be typical, at least for charge-based systems.
- The key to understanding differences in total costs across predominant sources of care is hospitalization. Other costs such as pathology, radiology, and even ambulatory physician visits, showed relatively small differences across different settings.
- For both the AFDC females and the disabled, the number of relative value units per physician visit, a measure of physician intensity of service, was remarkably close for both private practice and OPD sources of care. This

suggests similarity of ambulatory care patients in the two settings.

- There were substantial differences in the proportions of hospitalizations that can be categorized as permitting no physician discretion as to the need or timing of hospitalization across different settings of care. These differences were most marked for the AFDC females and stem to a great extent from differences in the predominant source of care for pregnant women. Given the demographics of the disabled, pregnancy is not a frequent medical condition for them. Nonetheless, there were also indications of greater hospitalizations for diagnoses permitting no discretion for the disabled with an OPD as their predominant source of care compared to a private practice.

- There are strong indications that "discretionary" surgery was more likely to be performed for patients whose predominant source of care was a private practice.

- When pregnant women are excluded from the sample,[17] the differences in the average total cost of care between OPD and private office patients for AFDC females disappear. (In fact, the mean cost for OPD patients was 14 percent less than for private practice patients.)

The patterns of cost and use for the disabled are similar to those of the AFDC females in many aspects, but significantly different too. Not only were the disabled more likely to be hospitalized, but there is some evidence that disabled patients whose PSC was the OPD had a greater likelihood of using a long-term care facility compared to either AFDC patients or disabled patients whose PSC was a private physician's office. We note that schizophrenia was the single most frequent hospital diagnosis for the disabled, which suggests that the psychiatric hospitals may also be serving as long-term care facilities. This would not explain, however, why the disabled from the OPD are more likely to use long-term care than those from private practice.

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[17] There is another reason for excluding pregnant women other than nondiscretion for hospitalization. California's Medicaid procedures allow for a flat payment to the obstetrician which includes all prenatal care as well as the delivery. Consequently, prenatal visits will not be covered by individual claims and would not be recorded in these data. This could lead to bias in the predominant source of care if women were to receive their prenatal visits at some PSC other than where they receive their other ambulatory care.

Basic Reimbursement Methods

States follow one of two basic methods for reimbursing providers of medical services. The first is cost reimbursement, whereby providers receive the "cost" of care, which is usually an accounting estimate of average actual costs per day or per service. This method, which has traditionally been used to reimburse short-term hospitals for inpatient care, has come under increasing criticism because of the incentive for providers to provide both more care and more expensive care. Many states reimburse outpatient visits to OPDs and emergency rooms on this basis.

The other method of reimbursement for medical services is a prospective payment system, whereby providers receive a predetermined fixed amount for a given visit or service. This method is frequently employed to reimburse physicians under a variant called a fee schedule, that is, a set of fixed predetermined prices for a given set of services. The U.S. Department of Health and Human Services has recently implemented a prospective payment system for Medicare's reimbursement for hospitals using Diagnostic Related Groups (DRGs); hospitals will receive a fixed dollar amount for a patient with a given set of criteria (e.g., age and diagnosis).

During the period of our study, California Medicaid reimbursed practically all providers of physician services on a prospective payment system. Although most states reimburse for physician visits provided in a private office on a prospective payment basis, California was somewhat atypical in that only a minority of states employ a fee schedule for OPD services.[18] It

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[18] See Muse and Sawyer (1982, pp. 116-118). California basically had a prospective payment system for reimbursing physician visits in an OPD, with some discounting of the fees compared to what physicians in private offices receive. In the first year of this study, the discount was 40 percent, but it was reduced to 20 percent in the latter two years (1977-1978).

is most likely that this OPD payment method has strong implications for how providers respond in their treatment of Medicaid patients, and the results presented above are probably dependent, therefore, on this OPD reimbursement method. In other words, the costs and patterns of care reported are, at least in part, a consequence of the payment method. Generalizing from these results, therefore, needs to take account of the differences that may exist in payment methods among states.

It appears, then, that one of the noteworthy findings of this study is that differences in total program costs per patient month between private practices and OPDs, in a state which uses a prospective payment system for both OPDs and private practice, need not be dramatically different.[19] More refined analyses as part of this or future projects may show differences in costs that offer opportunities for cost savings through appropriate restructuring of incentives. However, it seems clear from these data that the magnitude of the savings will be substantially less than what conventional wisdom has been suggesting.[20]

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[19] California hospitals were not particularly happy about the level of reimbursement they were receiving from Medicaid for OPD services. They argued that the charge should be linked to costs, and their costs (allegedly) exceeded what the state was willing to pay. (Personal communication, California Department of Health Services.) Apparently, a substantial legal suit brought by the California Hospital Association argued that paying charges independent of costs was an inappropriate basis for the state to use in reimbursing hospital OPDs. The case was decided in favor of the state.

[20] Determining the appropriate charge the state should pay for a service is not straightforward. Setting the charge too low is likely to decrease access or quality, since providers will be less willing to treat patients at that price. Setting the price too high will cost the program more than the social value of the services provided. And the social value of the services is ultimately a political and social judgment about where and what services the public wants to purchase for the Medicaid population. We are ignoring here any effects of the setting of ambulatory services on the use of inpatient care. For more details on this topic of what charges should be, see Held and Pauly (1983).

Many positive things can be said about a prospective payment system such as that used by California for reimbursing hospital outpatient departments. Such a system gives the hospital an incentive to minimize costs.[21] In addition, if similar services are reimbursed at similar rates regardless of where they are received, then providers and patients have incentives to choose among alternatives based on medical, ethical, and other values. In other words, fiscal incentives are not distorting the choice structure.

Our analysis has focused on the issue of total program costs per patient month; it is worth repeating that the cost of ambulatory care is only a minor part of the total. If ambulatory costs are controlled via a prospective payment system, it is the potential abuse of the admitting power to the hospital that should be of public concern. The results discussed here show that, within reasonable bounds of precision and our currently available data, it does not appear that the admission power of OPDs has been seriously abused if private practice physicians are used as a standard of comparison.

A natural extension of the prospective payment concept is for the state to pay a flat rate per patient for all medical services for a specified time period. This is, of course, the popular HMO (Health Maintenance Organization) concept. The data on pregnancies presented for the AFDC population and the use of long-term care facilities by the disabled highlight the issue of adverse selection, which is always a potential problem under capitation when either patients or providers can select each other in a fashion which is correlated with expected costs of care. Under a capitation scheme, providers have the obvious financial incentive to avoid any patient whose expected costs exceed the capitation amount. Although we have no precise explanation as to

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[21] Technically this is only true if the hospital maximizes profits, which may or may not be true for nonprofit hospitals.

why these above-average cost subgroups of the population were more likely to use an OPD, our data indicate that, indeed, they did. These examples of self-selection provide some evidence that design of a capitation plan for Medicaid recipients would need to be concerned with adverse selection. If design of a capitation plan does not consider such a danger, there are likely to be problems of reduced patient access and quality of care, or fiscal insolvency for providers.

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APPENDIX A

Supplementary Statistical Tables

Table A-1

Distribution of Predominant Source of Care by Age, Year, and Geographic Location for California Female AFDC Medicaid Eligibles 1976-1978

(Percent)

Location and Age	Year	Weight[b]	Predominant Source of Care[a]								
			Private Office		Public Hospital		Private Hospital		Clinic	Nonuser of Ambulatory Care	Total
			GP	Specialist	ER	OPD	ER	OPD			
All	1976	100	25.1	32.9	1.7	5.1	7.4	1.8	2.5	23.5	100.0
	1978	100	23.6	33.8	1.1	4.6	7.1	3.7	3.6	22.5	100.0
Rural Counties[c]	1976	12	35.7	19.7	1.7	4.1	6.6	2.1	4.0	26.1	100.0
	1978	12	29.7	20.5	1.2	4.1	6.1	3.6	9.1	25.8	100.0
Age Distribution											
Less than 1	1976	4	16.8	54.7	2.0	7.5	6.4	2.3	2.1	8.2	100.0
	1978	2	14.4	57.6	1.2	6.5	5.1	4.3	3.1	7.8	100.0
1-6	1976	25	16.4	32.0	1.1	4.6	10.6	1.5	2.8	31.1	100.0
	1978	25	17.7	40.9	0.3	3.0	10.4	1.7	1.2	24.8	100.0
15-24	1976	31	25.4	33.3	2.0	4.5	8.4	1.8	2.6	22.1	100.0
	1978	30	21.5	31.9	1.4	6.2	6.4	3.9	3.9	24.8	100.0
25-34	1976	24	28.3	32.0	1.7	6.8	6.0	1.4	2.2	21.5	100.0
	1978	26	27.6	30.7	1.5	4.5	6.6	5.2	5.5	18.5	100.0
35-49	1976	14	34.3	31.7	2.0	3.7	3.8	2.7	2.0	19.8	100.0
	1978	14	30.8	28.6	1.4	3.7	4.9	4.2	3.4	23.1	100.0
50-64	1976	3	38.4	23.5	0.7	6.1	2.4	2.6	3.4	22.9	100.0
	1978	3	35.6	30.4	0.4	6.4	1.7	4.1	2.6	18.8	100.0
(Sample Size)			(2174)	(2997)	(102)	(467)	(491)	(234)	253	1,904	8,622

NOTE: Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Six age cohorts are included. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles county and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department. GP is general practitioner.

b. Weight is the percent of the total sample, by year, in that row.

c. "Rural" includes 33 counties with low population densities and few population centers.

Table A-2

Distribution of Predominant Source of Care by Age, Year, Sex, and Location for California Disabled Medicaid Eligibles 1976-1978

(Percent)

			Predominant Source of Care[a]								
			Private Office		Public Hospital		Private Hospital				
Location, Age and Sex	Year	Weight[b]	GP	Specialist	ER	OPD	ER	OPD	Clinic	Nonuser of Ambulatory Care	Total
All	1976	100	24.8	25.4	2.0	6.5	3.3	3.3	1.8	32.9	100.0
	1978	100	23.1	31.4	1.3	4.3	3.1	4.3	1.9	30.8	100.0
Rural Counties[c]	1976	14	34.9	20.0	1.2	4.9	3.2	2.2	3.7	30.0	100.0
	1978	13	27.3	31.2	1.7	3.6	3.6	3.3	2.0	27.3	100.0
Female Distribution	1976	53	27.8	29.3	1.6	6.6	2.7	3.9	2.0	26.2	100.0
Male Distribution	1976	46	21.7	21.4	2.6	6.6	4.0	2.7	1.7	39.4	100.0
Age Distribution											
Less than 1	1976	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	1978	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1-6	1976	1	9.7	29.0	3.2	3.2	9.7	0.0	0.0	45.2	100.0
	1978	1	8.6	48.6	0.0	2.9	5.7	2.9	0.0	31.4	100.0
7-14	1976	2.3	11.5	29.9	2.3	2.3	2.3	5.8	1.2	44.8	100.0
	1978	2.3	12.3	45.2	0.0	0.0	2.7	2.7	2.7	34.3	100.0
15-24	1976	12	16.3	20.3	1.2	3.2	5.4	2.9	1.4	49.3	100.0
	1978	10	12.8	27.7	2.3	3.6	4.6	5.7	1.4	42.9	100.0
25-34	1976	16	21.7	18.9	1.5	5.2	5.7	4.1	2.0	40.9	100.0
	1978	16	18.3	24.7	2.1	2.9	4.1	3.6	2.9	41.2	100.0
35-49	1976	20	23.4	26.8	2.2	6.5	4.1	3.8	1.9	31.4	100.0
	1978	20	20.9	28.8	0.8	5.1	3.8	5.5	2.1	31.8	100.0
50-64	1976	49	29.4	27.8	2.3	8.1	1.6	2.9	1.9	26.2	100.0
	1978	50	28.6	34.2	0.0	4.8	2.1	3.9	1.5	24.1	100.0
(Sample Size)			(1939)	(2354)	(133)	(433)	(263)	(306)	(144)	(2579)	(8151)

NOTE: Based on a sample of 8,151 disabled eligibles. Those aged 65 years or older are excluded. Los Angeles county and drug claims are excluded. Eligibles who received care in a long-term care setting are included in these data; 0.8% were missing data on their sex.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department. GP is general practitioner.

b. The percent of the total sample, by year, in that row.

c. "Rural" includes 33 counties with low population densities and few population centers.

Table A-3

Mean Expenditures Per Eligible For California Female AFDC Medicaid Eligibles Excluding Pregnancies by Predominant Source of Care and Type of Service 1976-1978

(dollars)

Type of Service	Predominant Source of Care[a]					
	Private Office	ER	OPD	Clinic	Nonuser of Ambulatory Care	Total
Ambulatory Care Visits[b]	54.37	44.55	50.12	40.86	0.00	39.60
(Number of visits per eligible)	(4.02)	(3.47)	(3.82)	(3.10)	0.00	(2.87)
(RVUs/visit)	(21.62)	(28.21)	(20.44)	(21.27)	0.00	(21.99)
Hospital visits	4.92	4.95	1.61	4.43	0.74	3.64
Other Medical	18.17	11.81	12.23	7.86	4.41	13.52
Pathology	16.70	11.28	17.71	12.89	0.76	12.31
Radiology	11.97	12.52	12.70	7.43	0.37	9.14
Surgery	29.56	27.82	15.74	5.90	2.77	21.16
Inpatient Care	140.85	165.75	120.10	108.24	15.36	110.02
Proportion hospitalized	(.09)	(0.13)	(0.10)	(0.04)	0.01	(0.08)
Average length of stay	(5.35)	(5.14)	(4.26)	(7.51)	4.83	(5.16)
$ for those hospitalized	1,510.03	1,498.75	1,165.97	2,666.36	1,202.81	1,459.34
$/day for those hospitalized	281.66	284.55	277.20	355.17	249.19	282.67
Other Inpatient Care[d]	0.09	0.00	0.00	0.00	0.00	0.05
Hospital Examining Room[c]	0.70	0.44	2.29	0.78	0.05	0.62
Emergency Room[c]	1.33	5.35	1.91	1.03	0.33	1.46
Other[d]	27.70	26.75	27.39	11.71	6.35	21.15
Total Cost	307.18	311.47	264.31	202.63	31.20	234.24
(Sample Size)	(5083)	(580)	(667)	(244)	(1869)	(8443)

NOTE: Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Six age cohorts are included. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles county and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term care setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred. ER is emergency room. OPD is outpatient department.

b. Includes physician visits in all ambulatory settings regardless of predominant source of care for a given patient. RVU is relative value unit.

c. These charges are covered under California's Schedule of Maximum Allowances.

d. These services include home and nursing home visits, anesthesiology procedures, and other services covered under California's Schedule of Maximum Allowances.

Table A-4

Mean Expenditures Per Eligible For California Disabled Medicaid Eligibles by Predominant Source of Care and Type of Service 1976-1978

(dollars)

Type of Service	Predominant Source of Care[a]					
	Private Office	ER	OPD	Clinic	Nonuser of Ambulatory Care	Total
Ambulatory Care Visits[b]	62.52	43.90	57.91	67.86	0.00	41.61
(Number of visits)	(5.54)	(2.82)	(4.79)	(5.36)	0.00	(3.59)
(RVUs/visit	(19.67)	(27.31)	(19.71)	(19.46)	0.00	(19.95)
Hospital visit	17.86	12.28	7.56	13.03	2.24	11.41
Other Medical	42.58	51.97	35.66	45.04	18.41	34.82
Pathology	17.37	13.86	29.95	35.69	1.88	13.63
Radiology	19.75	21.03	32.24	18.58	1.23	14.93
Surgery	28.03	14.83	19.25	17.69	7.52	19.61
Inpatient Care[c]	274.21	413.36	501.46	293.11	110.78	246.02
Proportion hospitalized[d]	(0.16)	(0.30)	(0.20)	(0.12)	(0.05)	(0.13)
Average length of stay[c]	(9.44)	(9.47)	(11.92)	(10.85)	(13.25)	(10.35)
$ for those hospitalized[c]	1,616.92	1,368.31	2,226.42	2,385.16	1,951.77	1,726.77
$/day for those hospitalized[c]	172.64	140.13	184.63	219.83	147.33	166.89
Other Inpatient Care[e]	22.45	105.60	177.35	45.74	123.22	71.92
Hospital Examining Room[f]	0.92	0.94	5.48	0.54	0.08	1.05
Emergency Room[f]	1.36	4.35	1.23	0.94	0.09	1.10
Other[g]	56.50	89.77	100.24	57.20	24.81	51.81
Total Cost	555.09	804.07	1,000.24	599.82	297.26	520.74
(Sample Size)	(4290)	(396)	(739)	(144)	(2579)	(8151)

NOTE: Based on a sample of 8,151 disabled eligibles. Those aged 65 years or older are excluded. Los Angeles county and drug claims are excluded. Eligibles who received care in a long-term care setting are included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred. ER is emergency room. OPD is outpatient department.

b. Includes physician visits in all ambulatory settings regardless of predominant source of care. RVU is relative value unit.

c. Short term facilities only.

d. Includes long and short term facilities.

e. Long term facilities.

f. These changes are covered under California's Schedule of Maximum Allowances.

g. Other includes home and nursing home visits, anesthesiology procedures, and those services covered under California's Schedule of Maximum Allowances.

Table A-5

Distribution of Hospital Diagnosis Groupings by Predominant Source of Care
California Female AFDC Medicaid Recipients
1976-1978

Percent

Diagnosis Group	Predominant Source of Care[a]				
	Private Office	ER	OPD	Clinic	Total[b]
A. No discretion but also no indication of health status	34.18 (17.51)[c]	20.42 (12.46)	56.38 (13.95)	46.77 (4.15)	39.10 (15.60)
B. No discretion but also correlated with poor health	0.21 (0.29)	0.00 (0.00)	0.00 (0.00)	7.25 (13.05)	0.29 (0.42)
C. Delayable—quality of life choice	11.48 (15.44)	11.35 (13.79)	3.82 (8.03)	0.00 (0.00)	10.04 (14.63)
D. Don't know; not enough information	19.87 (22.94)	31.94 (30.85)	12.71 (22.24)	9.18 (16.56)	20.22 (25.23)
E. Physician discretion about whether and how to treat	25.80 (33.38)	30.56 (37.00)	23.78 (48.81)	36.81 (66.28)	24.16 (35.08)
F. Usually not hospitalized	8.05 (10.42)	4.86 (5.90)	3.30 (6.97)	0.00 (0.00)	6.20 (9.04)
Total	100.00 (100.00)	100.00 (100.00)	100.00 (100.00)	100.00 (100.00)	100.00 (100.00)
Unweighted sample size	559 (471)	64 (51)	101 (67)	19 (10)	805 (626)

NOTE: Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles county and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term care setting are not included in these data.

[a] Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department.

[b] Nonusers of ambulatory care are included.

[c] Numbers in parentheses are for the subsample which excluded women who had a delivery during the six month period of January through June.

Table A-6

Distribution of Hospital Diagnosis Groupings by Predominant Source of Care
California Disabled Medicaid Recipients
1976-1978

Percent

Diagnosis Group	Predominant Source of Care[a] Private Office	ER	OPD	Clinic	Total[b]
A. No discretion but also no indication of health status	15.89	30.59	22.44	21.05	20.51
B. No discretion but also correlated with poor health	3.15	0.00	1.21	5.26	2.36
C. Delayable—quality of life choice	7.98	1.95	4.28	15.79	6.81
D. Don't know; not enough information	28.46	21.50	26.80	10.53	27.13
E. Physician discretion about whether and how to treat	34.19	35.56	29.53	36.84	33.03
F. Usually not hospitalized	10.31	10.33	15.75	10.53	10.16
Total	100.00	100.00	100.00	100.00	100.00
(Sample Size)	(711)	(100)	(164)	(9)	(1102)

NOTE: Based on a sample of 8,151 disabled eligibles. Los Angeles county and drug claims are excluded. Those aged 65 or older are excluded. Eligibles who received care in a long-term care setting are not included in these data.

[a] Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department.

[b] Nonusers of ambulatory care are included..

Table A-7

Mean Expenditures Per Eligible for California Female AFDC Medicaid Eligibles Excluding Pregnancies
by Predominant Source of Care and Type of Service
1976-1978

Type of Service	Predominant Source of Care[a]								
	Private Office		Public Hospital		Private Hospital				
	GP	Specialist	ER	OPD	ER	OPD	Clinic	Nonuser of Ambulatory Care	Total
Ambulatory Care Visits[b]	52.47	55.73	36.03	44.80	46.26	58.60	40.86	0.00	39.60
(Number of visits)	(4.13)	(3.90)	(2.59)	(3.65)	(2.53)	(4.09)	(3.10)	(--)	(2.87)
(RVUs/visit)	(19.98)	(22.87)	(22.12)	(19.20)	(29.43)	(22.42)	(21.27)	(--)	(21.99)
Hospital visits	3.75	5.77	0.19	1.06	5.91	2.50	4.43	0.74	3.64
Other Medical	17.31	18.79	18.41	9.59	10.49	16.43	7.86	4.41	13.52
Pathology	15.36	17.67	10.41	16.47	11.46	19.68	12.89	0.76	12.31
Radiology	13.25	11.04	16.03	12.14	11.82	13.59	7.43	0.37	9.14
Surgery	23.40	33.99	7.43	16.46	31.91	14.61	5.90	2.77	21.16
Inpatient Care									
Short-Term hospital	111.60	161.91	92.58	128.52	180.44	106.68	108.24	15.36	110.02
(Proportion Hospitalized)	(0.08)	(0.10)	(0.22)	(0.12)	(0.11)	(0.08)	(0.04)	(0.01)	(0.08)
(Average Length of Stay)	(4.94)	(5.65)	(1.68)	(4.51)	(5.84)	(3.85)	(7.51)	(4.83)	(5.16)
$ for those hospitalized	1,340.22	1,632.34	393.99	1,109.39	1,720.55	1,256.21	2,666.36	1,202.81	1,459.34
$/day for those hospitalized	271.29	289.13	234.88	246.24	294.52	326.56	355.17	249.19	282.67
Hospital Examining Room[c]	0.61	0.70	0.36	1.77	0.46	3.12	0.78	0.05	0.62
Other Inpatient Care	0.03	0.13	0.00	0.00	0.00	0.00	0.00	0.00	0.05
Emergency Room[c]	0.78	1.65	4.16	1.80	5.60	2.09	1.03	0.33	1.46
Other[d]	22.37	29.11	11.91	22.70	29.73	35.53	11.71	6.35	21.15
Total Cost	263.06	338.96	198.38	257.13	334.17	275.75	202.63	31.20	234.24
(Sample Size)	(2151)	(2932)	(101)	(444)	(479)	(223)	(244)	(1869)	(8443)

NOTE: Based on a sample of 8,443 AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six 6 continuous months. Los Angeles county and drug claims are excluded. All data are dollars except those in parentheses. Those aged 7-14 years and those aged 65 or over are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department. GP is general practitioner.

b. Includes physician visits in all ambulatory settings regardless of predominant source of care. RVU is relative value unit.

c. These charges are covered under California's Schedule of Maximum Allowances.

d. Includes home and nursing home visits, anesthesiology procedures, and other services covered under California's Schedule of Maximum Allowances.

Table A-8

Mean Expenditures Per Eligible for California Disabled Medicaid Eligibles
by Predominant Source of Care and Type of Service
1976-1978

Type of Service	Predominant Source of Care[a]								
	Private Office		Public Hospital		Private Hospital				
	GP	Specialist	ER	OPD	ER	OPD	Clinic	Nonuser of Ambulatory Care	Total
Ambulatory Care Visits[b]	63.52	61.69	39.67	53.67	46.04	63.92	67.86	0.00	41.61
(Number of visits)	(5.71)	(5.41)	(3.44)	(4.81)	(2.51)	(4.77)	(5.36)	(--)	(3.59)
(RVUs/visit)	(19.21)	(20.05)	(21.30)	(18.03)	(30.35)	(22.08)	(19.46)	(--)	(19.95)
Hospital visits	7.29	26.58	11.30	4.54	12.78	11.86	13.03	2.24	11.41
Other Medical	33.36	50.18	27.33	32.40	64.41	40.27	45.04	18.41	34.82
Pathology	14.16	20.03	17.00	26.63	12.27	34.65	35.69	1.88	13.63
Radiology	14.39	24.18	22.01	35.44	20.53	27.72	18.58	1.23	14.93
Surgery	16.35	37.66	20.95	15.53	11.74	24.51	17.69	7.52	19.61
Inpatient Care									
Short-Term hospital	150.52	376.11	622.97	363.80	307.57	696.39	293.11	110.78	246.02
(Proportion Hospitalized)	(0.11)	(0.20)	(0.29)	(0.19)	(0.31)	(0.22)	(0.12)	(0.05)	(0.13)
(Average Length of Stay)	(8.04)	(10.60)	(13.00)	(9.78)	(7.69)	(14.95)	(10.85)	(13.25)	(10.35)
$ for those hospitalized	1,480.21	1,729.54	2,124.49	1,698.60	986.70	2,973.83	2,385.16	1,951.77	1,726.77
$/day for those hospitalized	184.22	163.10	163.42	173.62	128.38	200.22	219.83	147.33	166.89
Other Inpatient Care	16.50	27.35	175.24	44.69	70.46	365.22	45.74	123.22	71.92
Hospital Examining Room[c]	1.04	0.83	0.95	5.34	0.94	5.68	0.54	0.08	1.05
Emergency Room[c]	1.58	1.18	5.93	1.37	3.56	1.03	0.94	0.09	1.10
Other[d]	49.99	61.87	116.43	79.20	76.32	130.03	57.20	24.81	51.81
Total Cost	374.85	703.57	1,089.36	674.74	660.09	1,464.17	599.82	297.26	520.74
(Sample Size)	(1939)	(2354)	(133)	(433)	(263)	(306)	(144)	(2579)	(8151)

NOTE: Based on a sample of 8,151 disabled eligibles. Los Angeles county and drug claims are excluded. All data are dollars except those in parentheses. Those aged 65 or over are excluded. Eligibles who received care in a long-term setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department. GP is general practitioner.

b. Includes physician visits in all ambulatory settings regardless of predominant source of care. RVU is relative value unit.

c. These charges are covered under California's Schedule of Maximum Allowances.

d. Includes home and nursing home visits, anesthesiology procedures, and other services covered under California's Schedule of Maximum Allowances.

Table A-9

Distribution of Hospital Diagnoses Groupings by Predominant Source of Care, California Female AFDC Medicaid Recipient 1976-1978

Percent

	Predominant Source of Care[a]							
	Private Office		Public		Private			
Diagnosis Group	GP	Specialist	ER	OPD	ER	OPD	Clinic	Total[b]
A. No discretion but also no indication of health status	28.84 (18.08)[c]	38.03 (17.10)	5.11 (5.61)	47.82 (5.81)	24.55 (13.91)	70.03 (30.16)	46.77 (4.15)	39.10 (15.60)
B. No discretion but also correlated with poor health	0.00 (0.00)	0.36 (0.51)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	7.25 (13.05)	0.29 (0.42)
C. Delayable - quality of life choice	8.90 (10.39)	13.33 (19.14)	0.00 (0.00)	3.44 (6.72)	13.63 (16.70)	4.45 (10.63)	0.00 (0.00)	10.04 (14.63)
D. Don't Know; not enough information	18.18 (21.22)	21.09 (24.21)	83.58 (81.97)	15.85 (25.05)	21.57 (20.07)	7.71 (16.64)	9.18 (16.56)	20.22 (25.23)
E. Physician discretion about whether and how to treat	32.95 (38.47)	20.65 (29.65)	11.31 (12.42)	28.02 (52.90)	34.42 (42.18)	17.02 (40.68)	36.81 (66.28)	24.16 (35.08)
F. Usually not hospitalized	10.14 (11.83)	6.54 (9.39)	0.00 (0.00)	4.87 (9.52)	5.83 (7.14)	0.79 (1.89)	0.00 (0.00)	6.20 (9.04)
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Sample Size	190 (167)	369 (304)	10 (9)	68 (57)	54 (42)	33 (22)	19 (10)	805 (626)

NOTE: Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and eligible for 6 continuous months. Los Angeles county and drug claims are excluded. Six age cohorts are included. Those aged 7-14 or 65 or older are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term care setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. GP is general practitioner. ER is emergency room. OPD is outpatient department.

b. Nonusers are included.

c. Numbers in parentheses are for a subsample which excludes women who had a delivery during the six month period of January through June.

Table A-10

Distribution of Hospital Diagnoses Groupings by Predominant Source of Care, California Disabled Medicaid Recipients 1976-1978

Percent

Diagnosis Group	Predominant Source of Care[a]							
	Private Office		Public		Private			
	GP	Specialist	ER	OPD	ER	OPD	Clinic	Total[b]
A. No discretion but also no indication of health status	15.89	15.89	21.05	20.88	35.40	24.66	21.05	20.51
B. No discretion but also correlated with poor health	3.49	2.87	0.00	1.10	0.00	1.37	5.26	2.36
C. Delayable - quality of life choice	7.75	8.17	2.63	4.40	1.61	4.11	15.79	6.81
D. Don't Know; not enough information	27.13	29.58	28.95	26.37	17.74	27.40	10.53	27.13
E. Physician discretion about whether and how to treat	32.56	35.54	42.11	32.97	32.26	24.66	36.84	33.03
F. Usually not hospitalized	13.18	7.95	5.26	14.29	12.90	17.81	10.53	10.16
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
(Sample Size)	(258)	(453)	(38)	(91)	(62)	(73)	(9)	(1102)

NOTE: Based on a sample of 8,151 disabled eligibles. Los Angeles county and drug claims are excluded. Those aged 65 or older are excluded. Eligibles who received care in a long-term care setting are not included in these data.

a. Predominant source of care is defined as the setting where the maximum number of ambulatory physician visits occurred for a given patient. GP is general practitioner. ER is emergency room. OPD is outpatient department.

b. Nonusers are included.

Table A-11

Mean Selected Discretionary Surgical Procedures For California Medicaid Eligibles by Predominant Source of Care and Eligibility Status 1976-1978

Measure	Eligibility Status	Predominant Source of Care[a]					
		Private Office	ER	OPD	Clinic	Nonuser	Total
Total Dollars Paid	Female AFDC[b]	1.48	0.62	0.35	0.82	0.12	0.97
	Disabled[c]	2.94	0.30	0.65	0.68	0.19	1.69
Inpatient Dollars (% of Total)	Female AFDC	44.15	53.42	38.58	62.87	10.53	43.98
	Disabled	53.04	7.71	3.68	0.00	45.37	50.30
Total RVU's	Female AFDC	3.00	1.35	0.86	1.35	0.19	1.96
	Disabled	7.14	0.58	0.04	1.04	0.35	4.02
Inpatient RVU's (% of Total)	Female AFDC	51.78	64.72	50.72	65.50	13.43	51.90
	Disabled	57.91	13.04	3.57	0.00	57.14	55.92
Total Visits	Female AFDC	0.04	0.02	0.02	0.02	0.01	0.03
	Disabled	0.12	0.02	0.03	0.05	0.01	0.07
Inpatient Visits (% of Total)	Female AFDC	21.63	20.94	12.31	19.53	3.12	19.85
	Disabled	7.99	12.50	5.26	0.00	16.67	8.14

NOTE: Discretionary surgical procedures are a selected list of 11 procedures that require the discretion of the physician. Examples include arthrocentesis and cataract extraction.

[a] Predominant Source of Care is defined as the setting where the maximum number of ambulatory visits occurred for a given patient. ER is emergency room. OPD is outpatient department.

[b] Based on a sample of 8,622 female AFDC eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification.

[c] Based on a sample of 8,151 disabled eligibles, those aged 65 years or older are excluded. Los Angeles and drug claims are excluded.

Table A-12

Mean Statistics for "Special Diagnostic Studies" by Eligibility Status and Predominant Source of Care, California, 1976-1978

Eligibility Status	Predominant Source of Care[a]					
	Private Office	ER	OPD	Clinic	Nonuser	Total
AFDC - Total[b]						
No. of Services	0.01	0.01	0.01	0.01	0.00	0.01
No. of RVU's	0.78	0.57	0.28	0.06	0.03	0.52
Amount Paid ($)	0.40	0.27	0.14	0.02	0.02	0.26
AFDC w/o Pregnancy[c]						
No. of Services	0.01	0.01	0.01	0.00	0.00	0.01
No. of RVU's	0.69	0.31	0.31	0.07	0.03	0.45
Amount Paid ($)	0.33	0.18	0.16	0.02	0.02	0.22
Disabled[d]						
No. of Services	0.04	0.0	0.050	0.063	0.00	0.03
No. of RVU's	3.54	1.66	2.93	9.97	0.56	2.56
Amount Paid ($)	1.61	0.56	1.45	4.00	0.23	1.15

NOTE: Special Diagnostic Studies include 24 selected diagnostic procedures that can be billed by the physician, not including pathology or radiology. Examples include sigmoidoscopy, otoscopy. RVU is Relative Value Unit based on the 1969 California Relative Value Scale.

a. Predominant source of care is defined as the setting where the maximum number of physician visits occurred for a given patient. ER is emergency room. OPD is outpatient department.

b. Based on a sample of 8,622 AFDC female eligibles not eligible for prepaid care and Medicaid-eligible for at least six continuous months. Those aged 7-14 years old and those aged 65 or older are excluded. Los Angeles and drug claims are excluded. Data are weighted to correct for age cohort and geographic stratification. Eligibles who received care in a long-term care setting not included in these data.

c. The subsample of AFDC women which excluded those who had a delivery during the six- month period of January through June.

d. Based on a sample of 8,151 disabled eligibles. Los Angeles county and drug claims are excluded. Those aged 65 or older are excluded. Eligibles who received care in a long-term care setting are included in these data.

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